Chapter 8: Strategic Directions of Small Facilities

Small Facilities to Play Appropriate Role

The skill and dedication of the men and women who provide health care to the nation's veterans should not be judged by the size of the facility at which they work. Surveys of patient satisfaction indicate that, from the consumers' viewpoint, there is no correlation between facility size and the perceived quality of service.[1] Furthermore, some of the highest honors achieved in VA health care for overall quality and efficiency have been won by smaller facilities.[2]

However, the inherently lower volume of care provided at smaller facilities has undeniable implications for specific types of procedures (the clear relationship between volume and outcomes for certain medical and surgical procedures is discussed below).

The CARES process therefore included an in-depth review of small facilities, to assure that they will play an appropriate role in providing high quality, cost-effective care throughout the VA system. A Small Facility Planning Initiative process was instituted to determine if and how resources, facilities, and services should be realigned to provide acute care in the future. The specific objectives were:

- To assure provision of cost-effective, appropriate, high quality patient care. "Quality" includes clinical proficiency across the spectrum of care, safe environment, and appropriate facilities.
- To evaluate the functioning of small facilities within each market and VISN as part of VA's health care delivery system.
- To consider each small facility's role in meeting projected acute inpatient care demand.

Overview

As described in detail in the Overview section of Chapter 6 of this Plan ("Ensuring Inpatient Capacity"), there have been striking changes in American medicine in recent years, prominently including a fundamental shift to ambulatory care. The changes from inpatient to outpatient care have been coupled with and, to a large extent, made possible by rapid advances in medical technology, which require on-going investment in imaging equipment.[3]

Recent emphasis on patient safety and outcomes in acute care settings, especially from surgical procedures, point to a need to rethink how the VA delivers health care across its system of hospitals and clinics.

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[1] American Customer Satisfaction Index, 2002.

[2] Examples: Grand Junction, CO, won the 2001 Presidential Award for Quality; Erie, PA and Walla Walla, WA, VAMCs received VA's top-ranked Carey Award for Quality in 2001.

[3] Ludmerer, KM, *Time to Heal* [Oxford University Press: Oxford, New York, 1999], pp.176-177, 319.

Many of the technological advances and the patient safety/quality emphases favor a reduction and consolidation of beds in centers that can provide state-of-the-art and "cutting edge" medicine to our nations' veterans[4]. VA medical centers can no longer provide care that only meets local standards of quality, but increasingly must aim to be part of a "world class" system of health care delivery. VA's own recent study of outcomes in patients with acute cardiovascular events pointed out that veterans were being referred for interventional treatment at less than the rate of Medicare patients and were being referred later.[5] Networking and early referral has been shown to improve outcomes for rural health care providers.[6] Likewise, the medical literature and consumer groups, like the Leapfrog group, have emphasized the relationship between volume and outcomes for certain kinds of procedures and for intensive care unit (ICU) treatment.[7,8,9,10, 11]

The VA has felt the impact of these changes, particularly in its small medical centers. Responses have ranged from closing surgery or medicine acute beds to consolidation of two or more acute care facilities. Many of the medical centers with low workload and small acute bed sections chose to close, due to one or more of the following factors: staff proficiency, quality of care, small ICU bed numbers, staff retention, cost of capital improvements, and availability of other health care options in their communities.[12]

At the same time, other small VA facilities have recognized and attempted to meet the health care needs of veterans in areas where access to care and the availability of other alternative providers is limited. Rural health care initiatives developed and used by the Centers for Medicare and Medicaid Services (CMS) to support access to acute care in remote areas have resulted in the adoption of a "Critical Access Hospital" (CAH) model for Medicare reimbursement.[13]

In order to qualify for CAH reimbursement from Medicare, facilities must meet the following criteria[14]:

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[4] e.g., an abdominal aortic aneurysm can be stented, using minimally invasive surgery with a LOS of 24 to 48 hours as compared to many days to a few weeks for an open surgical repair.

[5] Note current approaches to cardiovascular care favor an "early invasive" approach. [For the VA Report: http://www.va.gov/opp/eval/1_Table%20of%20Contents.pdf] See also: American College of Cardiology/American Heart Association Practice Guidelines, 2002 [http://www.circulationaha.org/].

[6] Johnson, DE, Network Improves Rural Care, *Health Care Strategic Management, 9(12):* 8, 1991.

[7] Birkmeyer, JD et al., Hospital Volume and Surgical Mortality in the United States. NEJM [New England Journal of Medicine] 346: 1128-37, 2002. [Editorial same issue: Volume and Outcome – It is Time to Move Ahead, pp. 1161-164.]

[8] Bach, PB, et al., The Influence of Hospital Volume on Survival after Resection for Lung Cancer. NEJM 345: 181-188, 2001.

[9] Canto, JG, et al., The Volume of Primary Angioplasty Procedures and Survival after Acute Myocardial Infarction. NEJM 342: 1573-1580, 2000.

[10] Begg, DB, et al., Variations in Morbidity after Radical Prostatectomy. NEJM 346: 1138-1144, 2002.

[11] http://www.leapfroggroup.org

[12] Examples include: Manchester, NH; Bath, Batavia, & Canandaigua, NY; Bonham, TX; White City, OR; Livermore, CA; Lincoln and Grand Island, NB.

[13] Created by the Balanced Budget Act of 1997 (BBA) as part of the Medicare Rural Hospital Flexibility Program.

[14] http://www.hospitalconnect.com/aha/member_relations/cah/faq.html [AHA website-FAQs]

- Must be located more than 35 miles from the nearest hospital (waivers and flexible interpretation have been allowed);
- Must be deemed by the state to be a "necessary provider;"
- Must have no more than15 acute beds [with up to 25 beds total, including "swing" beds for respite/hospice and/or SNF (skilled nursing facility) services]; [ICU beds are discouraged];
- Cannot have length of stays (LOS) greater than 96 hours (except respite/hospice);
- Must be part of a network of hospitals;
- May use physician extenders (Nurse Practitioners or Physician's Assistants or registered Nurse Midwives) with physicians available on call.

In practice, CAH providers have filled an important need for health care services, as many are located in areas designated as shortage areas.[15] The most common diagnoses treated in CAHs are acute respiratory and acute gastrointestinal disorders.

CARES Criteria
In order to be selected as a "small facility" for the purposes of CARES, a facility had to meet of the following three criteria:

- Had to provide **acute** hospital bed services;
- Had to have acute **medicine** beds;
- The total of projected acute beds for **medicine, surgery** and **psychiatry** in 2012 and 2022 had to be less than 40 beds.

Each market with one or more of the 19 identified "small facilities" received the *Handbook for Market Plan Development* (available in References) to provide instructions for the small facility evaluation process. The guidance required development of a minimum of three scenarios (with an optional fourth or 'combination' scenario):

- Retain acute hospital beds;
- Close acute hospital beds and reallocate workload to another VHA facility;
- Close acute hospital beds and implement contracting, sharing or joint venturing for workload in the community;
- Optional: Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

It should be noted that the CARES planning process only addressed the acute care missions of small facilities and did not address the long-term care or chronic psychiatry missions of VA facilities. Therefore, any recommendations refer only to the **acute** care beds.

[15] For references, see Appendix N.

Table 8.1 lists the 19 facilities with Small Facility Planning Initiatives that met the selection criteria, which used FY2001 as the base year.[16]

Table 8.1 Small Facility Planning Initiatives

VISN & Facility	Baseline Beds	Projected 2012	Projected 2022
V03 Hudson Valley	10	13	9
V04 Altoona	19	19	13
V04 Butler	9	10	8
V04 Erie	18	14	10
V06 Beckley	32	15	10
V07 Dublin	33	36	30
V11 Fort Wayne	26	17	14
V11 Saginaw	13	25	20
V15 Poplar Bluff	18	15	11
V16 Muskogee	25	37	29
V17 Kerrville	22	15	12
V18 Prescott	29	28	22
V19 Cheyenne	14	17	14
V19 Grand Junction	23	24	18
V20 Walla Walla*	34	40	36
V23 Des Moines	39	34	24
V23 Hot Springs	31	23	20
V23 Knoxville	27	26	20
V23 St. Cloud	21	26	18

**22 bed Psychiatry Residential Rehab. Program included in 34 beds, actual acute beds are 14*

Review and Recommendations For Small Facility Planning Initiatives

Evaluations of each small facility were incorporated into a criteria-driven checklist for detailed review of each VISN-level proposal submitted. Supplemental data that were considered consisted of the following:

- Cost data and scenario inputs on the VSSC CARES Portal (web-site);
- Patient Satisfaction Survey data from FY2002 (courtesy of the SHEP/PACE Office);
- Lists of surgical procedures performed at each of the small facilities (by volume and code) for FY2001 and FY2002;
- Average bed day of care (BDOC) costs compared to Medicare unit costs for each of the small facilities for Medicine, Surgery, and Psychiatry beds;
- Top diagnosis related group (DRGs) with average length of stay (ALOS) for each small facility;
- Distance to the nearest VA Facility as determined independently (using MapPoint software);
- Literature reviews as appropriate, including Medicare Critical Access Hospital (CAH) Guidance (Appendix N).

A summary of the recommendations from the small facility review follows. Table 8.2 shows the final recommendations on small facilities as recommended for

[16] Based upon BDOC projections after updating for Census 2000 in January 2003.

implementation by the Under Secretary of Health. Appendix F includes detailed recommendations for small facilities.

Retain Acute Hospital Beds

Eleven medical centers would retain their acute hospital beds, but would have a restricted "scope of practice" that would limit surgical inpatient beds and intensive care unit beds. Surgery beds would be converted to 'observation' beds.

Convert Acute Beds to Critical Access Hospital Model

Seven of the eleven facilities would convert their acute beds to CAH-like model. Several medical centers already met the CAH criteria: low acuity levels; short ALOS (less than four days); a decreasing number of acute care beds; and few, if any, ICU beds. Nevertheless, of the remaining small facilities reviewed, most showed a longer ALOS (than Medicare), although there was a mixed picture with respect to cost per BDOC (which was lower than contract costs in some, and higher than contract cost for others). Though costs for conversion to a CAH-like operation could not be estimated at the time of the review, such conversions were expected to reduce in-house operating costs. Nonetheless, one of the key drivers in recommending a transition to a CAH-like model of acute care delivery was the expectation that the quality of care and patient outcomes could be improved by:

- Greater coordination of care (at the VISN and Market levels);
- Earlier transfer and/or referral of complex cases; and
- Consolidation of volume-dependent cases in tertiary care facilities.

Other overriding factors supporting the "retain acute bed" option included a facility's role as a local health care provider in the community, the distance to another VHA facility, and innovative consolidations.

Closure of Acute Hospital Beds

Eight medical centers were recommended for closure of acute hospital beds over the next several years. One facility's acute bed closure would occur as a transition. In Altoona, the transition would occur after 2012, when beds are expected to decline much further. Knoxville's acute and long-term beds would be closed through a consolidation of Knoxville with Des Moines, which is a distance of 44 miles. The majority of these facilities are proposing to provide inpatient care through a combination of referrals to another VA medical center and community hospital(s). The intention of the acute bed closures is to keep access local, maintain customer satisfaction through better access, and improve cost efficiencies and patient outcomes.

Other

In addition, Big Spring, Texas (VISN 18) will close inpatient surgery. Big Spring will be reviewed as a realignment issue and studied for the possibility of no longer providing health care services on the Big Spring campus. Development of a Critical Access Hospital, that would include a plan for a nursing home and expansion of an existing clinic to a multi-specialty outpatient clinic, will be explored for the Odessa-Midland area.

Table 8.2 Small Facility Recommendations

		Small Facilities Review Recommendations					
Facility	**VISN**	**Retain Acute Beds***	**Convert to 'CAH-like' model**	**Contract and/or Refer**	**Decrease and/or review Surgery**	**Close or review ICU beds**	**Comments**
Hudson Valley Castle Point	3	Y	Y		N/A	N/A	Enhanced Use at Montrose. Castle Point retains beds. Convert to CAH .
Erie	4	Y	N		Y	Y	Convert inpt to outpt. surgery w/ (with) surgery observation (obs.) beds. Eval. ICU.
Beckley	6	Y	Y		Y	Y	Convert inpt to outpt surgery w/ obs. beds; convert to CAH. Close ICU beds.
Dublin	7	Y	N		Y	Y	Transition inpt surg. to outpt w/ obs. beds. Eval. ICU beds
Poplar Bluff	15	Y	Y		N/A	N/A	Functioning as CAH at present
Muskogee	16	Y	N		Y	Y	Convert inpt to ambulatory surgery w/ surg. observation (obs.) beds. Eval. ICU. Eval. Psych. bed expansion
Prescott	18	Y	N		N/A	N/A	Bed expansion to lessen demand pressure on Phoenix
Cheyenne	19	Y	Y		Y	Y	Convert to CAH, close ICU and continue surgery but w/ limited scope of practice.
Grand Junction	19	Y	Y		Y	Y	Convert to CAH, close ICU and continue surgery but w/ limited scope of practice.
Des Moines	23	Y	N		Y	Y	Move acute beds from Knoxville to Des Moines. Eval. ICU & for reduced scope of surgical practice.
Hot Springs	23	Y	Y	Y	N/A	N/A	Convert to CAH; decreased beds w/ increased contract/referral
Altoona	4	Transi-tion	Y	Y	N/A	Y	Implement closure of acute beds by 2012; interim, convert to CAH
Butler	4	N	N/A	Y	NA	NA	Transfer medicine services to Pittsb. & contract emergency care
Fort Wayne	11	N	N/A	Y	NA	NA	Acute medicine would close by contracting and transferring to other VAMCs
Saginaw	11	N	N/A	Y	NA	NA	Acute medicine would close by contracting and transferring to other VAMCs
Kerrville	17	N	N	Y	N/A	N/A	Implement in coordination with San Antonio capacity; in interim, convert to CAH.
Walla Walla	20	N	N/A	Y	NA	NA	Contracted beds only
Knoxville	23	N	N/A	N	NA	NA	Consolidate with Des Moines
St. Cloud	23	N**	N/A	Y	N/A		Transfer medicine services to Minneapolis & contract
TOTAL "YES"		**11**	**7**	**8**	**7**	**8**	
Converting to Contract/Referral or consolidation:		**8**					
Total Facilities Reviewed:		**19**					

***Except ICU & surgery beds**

****Acute Psychiatry beds will remain open**

Conclusions

The transition from an emphasis on inpatient care to outpatient care has been based upon advances in medical technology and therapy. In addition, for the VA, declining inpatient care has been coupled with an expansion of primary care, outpatient specialty care (especially ambulatory or 'same day' surgery), and better case management. The trend towards more sophisticated imaging and advances in invasive techniques, which shorten hospital stays but require the investment in expensive major equipment, has led to a further consolidation of care in tertiary care facilities of more complex cases. Optimal and efficient functioning of the VA's health care delivery system depends upon early referral and transfer of patients with complicated conditions and those requiring major surgery, where outcomes may be volume-dependent.

These trends have led to declines in bed days of care in smaller facilities to the point at which staff proficiency and outcomes may be compromised in low-volume sites. Moreover, economies of scale in provision of the latest medical and imaging technology cannot be realized. Nevertheless, many small VA medical centers (VAMCs) are important providers of health care in their communities. Several have already managed to achieve an appropriate level of functioning by decreasing their ALOS and early referral of patients with conditions beyond their scope of services. Others (by choice or through recommendation) would close their acute beds and manage acute patients through a combination of referral to other VAMCs and to community hospitals. The specific solutions to the issues of access to acute care depend upon the location of the facility and the availability and quality of alternative health care providers.

In response to the impact of the changes described above, many private sector rural hospitals closed or became no longer viable. In an effort to support access to acute care in rural areas, CMS began funding "Critical Access Hospitals" through Medicare in 1999. Reimbursement under Medicare was linked to meeting certain criteria and operational standards, as well as JCAHO accreditation (from 2002 onwards).[17]

The CARES review of small facilities in the VA has proposed a CAH-like process of designating small facilities, requiring that they meet certain operational standards and restricting their "scope of practice." The intent of this process would be to improve the efficiency, effectiveness, and to enhance the level of functioning of, small facilities within the context of VA's national system of health care delivery. Over the course of the next year, the VA will develop and implement policies to govern the operation of acute beds in small VA facilities, which may fit into a CAH-like model of health care delivery.

[17] Note: according to a GAO study, while Medicare reimbursement is 'at cost', pilots in Montana (called "Medical Assistance Facilities") showed that Medicare costs were less expensive than treatment would have been in full service rural hospitals. [GAO/HEHS-96-12R, Oct. 1995.]